

# State Employee Health Plan

## COBRA Participants

Open Enrollment Period is  
October 1 - October 31, 2015

Elections are effective January 1, 2016

## COBRA OPEN ENROLLMENT NOTIFICATION 2016

The annual State Employee Health Plan (SEHP) COBRA open enrollment period is your opportunity to make changes to your health care coverage such as changing medical carriers or adding/dropping dependents from coverage. **There are plan design changes for Plan Year 2017. COBRA rates are also increasing effective January 1, 2017.**

It is very important that the premium payments for your current COBRA coverage are paid through the end of 2016 or you will not be eligible for COBRA continuation coverage in the upcoming plan year. **Premium payments must be made even if you do not receive a monthly invoice.** All premium payments are due on the first day of each month and must be postmarked by the end of the 30 day grace period allowed from the due date.

If there are special circumstances that apply to your COBRA continuation coverage, such as extended benefits due to disability, please contact COBRAGuard at 866-952-6272 for the 2017 rates.

**DEADLINE:** Open Enrollment elections must be completed online no later than Monday, October 31, 2016. To enroll go to <https://sehp.member.hrissuite.com/> - complete enrollment instructions are on page 7 of this book.

**REMINDER:** The option to opt out or enroll in a different dental coverage tier than medical enrollment is now available. You and your covered dependents must still be enrolled in medical to enroll in Dental coverage.

**REMINDER: If you are adding dependents, you must upload the appropriate supporting documentation when you enroll online.**

For a list of appropriated supporting documentation, please visit the SEHP website at [www.kdheks.gov/hcf/sehp/DependentDoc.htm](http://www.kdheks.gov/hcf/sehp/DependentDoc.htm) You may also submit documentation to:

COBRAGuard, Inc.  
SEHP 2016 Open Enrollment  
P.O. Box 504216  
St. Louis, MO 63150-4216

## Contact Information

### **Aetna**

Customer Service Plan A and Plan C  
Behavioral Health (MHNet)

[www.aetnastateofkansas.com](http://www.aetnastateofkansas.com)

All Areas (Toll Free): 866-851-0754

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### **Blue Cross and Blue Shield of Kansas**

Customer Service Plan A and Plan C

New Directions - **Behavioral Health**

New Directions - **Autism**

[www.bcbsks.com/CustomerService/Members/State/](http://www.bcbsks.com/CustomerService/Members/State/)

All Areas (Toll Free) 800-332-0307

Topeka: 785-291-4185

All Areas (Toll Free) 800-952-5906

Topeka: 785-233-1165

All Areas (Toll Free) 877-563-9347 Option 3

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### **Caremark**

Customer Service

Caremark Connect Specialty Pharmacy

[www.caremark.com](http://www.caremark.com)

All Areas (Toll Free): 800-294-6324

TDD (Toll Free): 800-863-5488

All Areas (Toll Free): 800-237-2767

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### **COBRAGuard - COBRA Administrator**

Customer Service

[www.cobraguard.net](http://www.cobraguard.net)

All Areas (Toll Free): 866-952-6272

Fax: 913-438-8385

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### **Delta Dental of Kansas, Inc.**

Customer Service

[www.deltadentalks.com/](http://www.deltadentalks.com/)

All Areas (Toll Free): 800-234-3375

Wichita: 316-264-4511

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### **Preferred Lab Benefit Program**

- **Quest Diagnostics Lab Card Program**

Customer Service

Collection Site Listings

[www.labcard.com](http://www.labcard.com)

All Areas (Toll Free): 800-646-7788

[www.labcard.com/collection.html](http://www.labcard.com/collection.html)

- **Stormont-Vail Regional Lab Program**

Customer Service

Benefit Information and Collection Site Listings

[www.stormontvail.org/state-employees-lab](http://www.stormontvail.org/state-employees-lab)

All Areas (Toll Free): 800-637-4716

Topeka: 785-354-1150

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### **Surency Vision**

Customer Service

[www.surency.com](http://www.surency.com)

All Areas (Toll Free): 866-818-8805

Wichita: 316-462-3316

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## HIGHLIGHTS FOR PLAN YEAR 2017

### PLANS

There are two (2) Plans to choose from - Plan A or Plan C.

### MEDICAL VENDORS

There are two (2) medical vendors to choose from - Aetna and Blue Cross and Blue Shield of Kansas.

### WHAT'S CHANGING?

#### NEW HEALTHQUEST VENDORS

Cerner and Naturally Slim - more information to come.

#### DELTA DENTAL

Dental premiums of \$6.00 per pay period now apply to Employee only coverage. The option to opt out or enroll in a different coverage tier than medical enrollment is available. You and your covered dependents must still be enrolled in medical to enroll in Dental coverage.

Basic Plan Major Restorative Coinsurance has increased.

#### PLAN A

##### Office visit Copays are increasing by \$10:

- Primary Care Provider - \$40
- Specialist - \$60

##### A three (3) tiered Deductible will now apply.

**Network Deductibles** are \$1,000 Employee only, \$2,000 for Employee & 1, and \$3,000 for Employee & 2 or more.

**Non Network Deductibles** are \$1,200 Employee only, \$2,400 for Employee & 1 and \$3,600 for Employee & 2 or more.

##### Combined pharmacy and medical Network Out Of Pocket (OOP) maximums are:

- Single: \$5,750
- Family: \$11,500

##### Caremark Pharmacy Tiers will now be:

- Generic - 20% Coinsurance (no change)
- Preferred Brand Name - 40% Coinsurance
- Non Preferred Brand Name - 65% Coinsurance
- Special Case Medication - 40% to a maximum of \$100/30 day supply
- Anti Cancer Oral Medications - 20% Coinsurance to a maximum of \$100/30 day supply
- Discount Tier Medications - 100% Coinsurance the same as Plan Year 2016

##### Chronic Care Benefit

- Generics - 10% to a maximum of \$20 per 30 day supply
- Preferred Brands - 20% to a maximum of \$40 per 30 day supply

##### Compound Medications now must be filled at Network pharmacies only.

- 90 day supplies of most drugs available on Plans A and C

#### PLAN C HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

**Network Deductibles are \$2,750 Single and \$5,500 Family.**

##### Coinsurance added after the Deductible.

##### After Deductible is satisfied:

- Plan C will now have a Coinsurance added after the Deductible is satisfied.
- Network medical claims will apply 20% Coinsurance
- Pharmacy Coinsurance tiers will apply.

##### Caremark Pharmacy Tiers will be:

- Generic - 20% Coinsurance
- Preferred Brand Name - 40% Coinsurance
- Non Preferred Brand Name - 65% Coinsurance

- Anti Cancer Oral Medications – 20% Coinsurance
- Discount Tier Medications – 100% Coinsurance (no change)

**Chronic Care Benefit is not available on Plan C.**

**Compound Medications now must be filled at Network pharmacies only.**

**90 day supplies of most drugs available on Plans A and C**

**Non Network medical claims Coinsurance will increase to 50% Coinsurance.**

**Combined pharmacy and medical Network Out Of Pocket (OOP) maximums are:**

- Single: \$5,000
- Family: \$10,000

## CHOOSING YOUR HEALTH PLAN:

### Plan A or Plan C High Deductible Health Plan

**You have access to both health plans regardless of where you live.**

You have choices when it comes to your health care coverage. Choosing the appropriate health plan for you and your family is easier than you think!

**The State Employee Health Plan offers two health plan options:**

- Plan A
- Plan C with Health Savings Account (HSA) **or** Health Reimbursement Account (HRA).

**Please review the Health Plan Comparison Chart at the back of this book to see the differences in the Deductible, Coinsurance and Out Of Pocket maximums for Plans A and C.**

Each option is designed differently (for example, Deductibles, Coinsurance and Out Of Pocket maximums) and each health plan vendor offers unique features. Be sure to consider these features before making your selection.

**There are two health plan vendors:**

- Aetna
- Blue Cross and Blue Shield of Kansas

Each health plan vendor has a unique network of contracting providers. Since Network Providers agree to accept the plan allowance as payment in full, using Network Providers saves you money! Non Network Providers have not agreed to accept the plan allowance, so in addition to your required Out Of Pocket, any amount above the plan allowance will be your responsibility.

Provider Directories are listed on each vendor page on our website - [www.kdheks.gov/hcf/sehp/default.htm](http://www.kdheks.gov/hcf/sehp/default.htm)

### Both Vendors offer the following:

- Access to a broad network of providers nationwide which allows you flexibility in obtaining care with coverage for both Network and Non Network Providers.
- 100 percent coverage for certain preventive care services, such as an annual preventive exam, colonoscopy, mammograms and age-appropriate immunizations (including flu shots).
- Policies have no lifetime maximum.
- Prescription drug coverage through Caremark. See page 12 for details.
- Preferred Lab Benefit programs available through either Quest Diagnostics or Stormont-Vail HealthCare.

### Plan C has a few differences including:

- Premiums for coverage are lower than those for Plan A.
- Most covered services are subject to the Deductible and/or Coinsurance. See the Health Plan Comparison Chart included with this booklet to see the Deductibles, Coinsurance and Out Of Pocket costs.
- The Plan C Caremark Preferred Drug List is the same as Plan A's Preferred Drug List. With Plan C, prescription drug purchases are subject to the Deductible and Coinsurance tier level. Network claims for covered prescription drugs are subject to the Deductible then the appropriate tier level Coinsurance applies until the Out Of Pocket is met.

## ONLINE ENROLLMENT

- COBRAGuard participants will enroll online through the Membership Administration Portal (MAP) at <https://sehp.member.hrissuite.com/>

## BEFORE YOU ENROLL

- **Become familiar with your options.** For information on the health plans, vendors and more, review this booklet which includes the *Health Plan Comparison Chart* in the back, or go to our website - [www.kdheks.gov/hcf/sehp/default.htm](http://www.kdheks.gov/hcf/sehp/default.htm)
- **If you are thinking about changing your medical vendor** be sure your doctors and hospital participate with the new vendor you select for Plan Year 2017. Both medical vendors, Aetna and BCBS of Kansas, have unique provider networks. Provider Directories are listed on each vendor's page.
- **If you are adding dependents to your plan** and have **not** previously submitted the required documentation (such as a birth certificate or marriage license) to Membership Services, you will need to upload the documentation (an electronic version like a pdf) when you enroll online. Other pieces of information needed for each new dependent are the dependent's full name, Social Security number, gender and date of birth.

### QUESTIONS?

- **Contact the vendor.** Toll free customer service numbers are listed on the inside cover of this booklet.
- **Visit our website** - [www.kdheks.gov/hcf/sehp/default.htm](http://www.kdheks.gov/hcf/sehp/default.htm)
- **Send an e-mail** to [benefits@kdheks.gov](mailto:benefits@kdheks.gov)

**Pending Elections Statements** will be automatically sent to the e-mail address you register with online when you make your election choices and can be viewed in MAP. This statement is not a final notification of your elections. Once your elections have been reviewed and approved by the SEHP after open enrollment has ended, you may view your final elections in MAP.

## ENROLLING FOR HEALTH CARE BENEFITS

**The Annual Open Enrollment Period is October 1 through October 31.** Your benefit elections become effective January 1 of the following year. Unless you experience a "qualifying event" during the plan year, your decisions are binding until the next annual open enrollment period.

Qualifying events include life-altering events such as the birth or adoption of a child, marriage, divorce, death of a spouse or a dependent, or gain or loss of employment and benefits for a spouse or a dependent.

**Changing Your Coverage** - Health plan changes due to a qualifying event during the plan year must be consistent with the event. The change must be made in the Membership Administration Portal (MAP) within 31 days of the event in order for the change to be effective the first day of the month following the event. If the event takes place on the first day of the month, the effective date will be that day. **Note:** If the change is not completed within this 31-day period, it will need to be requested during the next open enrollment period.

**Note:** In the event of a divorce, coverage for your former spouse and stepchild(ren) ends on the day the divorce is finalized.

### Newly Hired or Newly Eligible Employees

You have 31 days after the date you are hired or become eligible to enroll in your choice of coverage. Your coverage will become effective on the first day of the month after the completion of a 30-day waiting period. If you do not enroll by the deadline, you will not be eligible to enroll until the next open enrollment period (unless you experience a "qualifying event" that allows you to make a change).

### Who Can Be Covered

In addition to covering yourself, you also can elect coverage for your eligible dependents. Your eligible dependents include:

- Your lawful spouse.
- Your child(ren) or stepchild(ren). To be covered under your health plan, your child(ren) or stepchild(ren) must be under the age of 26.

During the open enrollment period, the required documentation must be submitted online in the Membership Administration Portal (MAP). If dependent documentation is not received, the dependent(s) will not be enrolled in the health plan effective January 1, 2017.

# OPEN ENROLLMENT MEMBERSHIP ADMINISTRATION PORTAL (MAP) USERS INSTRUCTIONS

COBRA participants wanting to make changes to their State Employee Health Plan (SEHP) benefits for Plan Year 2017 must complete their open enrollment elections online in the SEHP Membership Administration Portal (MAP) <https://sehp.member.hrissuite.com/>. Members can enroll online using any computer with Internet access – at work, home, or at most public libraries. All modern Internet browsers will work; Internet Explorer 9 and above, Chrome, Firefox, Safari, and Opera.

**Technical Support During the Open Enrollment Period, October 1st through October 31st:** If you experience any technical issues with this portal, call the MAP Help Desk at 1-800-832-5337 (Toll Free). The MAP Help Desk will be open from October 1st through October 31st Monday – Friday 7 AM to 5 PM and Saturday 9 AM to 2 PM Central Time.

**Technical Support After Hours during Open Enrollment:** Please e-mail: [techsupport@hrissuite.com](mailto:techsupport@hrissuite.com) Include your name, phone number, and an explanation of your issue and they will troubleshoot your issue and contact you within 24 hours with a resolution.

Starting October 1st, you can visit MAP to register your online account (if you are a new member), review your contact information, Member & Family Information, and your current SEHP elections. You can make any changes you want for plan year 2017. The following information will provide you with step-by-step instructions on how to register your account and complete your open enrollment. Note: You only need to register your account and create a unique login the first time you access MAP. Once you have registered, you will be able to sign in to MAP with your username and password.

**\*Before you begin, make sure you have the following information ready\***

- Your Kansas Employee ID number (available from your COBRA Open Enrollment packet)
- The last 6 digits of your Social Security number (SSN)
- Your Date of Birth

**Adding a new dependent?** Dependent documentation in pdf format will need to be scanned and uploaded into MAP at the time the member is requesting to add a new dependent.

## Enrollment Instructions

Go to MAP at: <https://sehp.member.hrissuite.com/>



- The Welcome screen will appear. If this is the first time you are logging into the portal, please click on the **“Register Now”** button to get started. If you have previously registered, click on the **“Sign In”** button.
- Follow the instructions on the screen

You may go into MAP as many times as needed during the Open Enrollment period to make changes. Pending elections statements will be emailed to your registered email address each time an election is saved in the portal. The selection saved as of midnight on October 31, 2016 will become effective January 1, 2017. Your approved elections will be viewable in MAP by December 1, 2016.





## Prescription Drug Plan

Prescription drug coverage is provided through Caremark for Plans A and C, and its cost is included in the health plan rates. While the Preferred Drug List (PDL) is the same for both plans, the amount you pay will vary depending on the plan you select as explained below.

- **Plan A.** Under this plan, generally you pay a Coinsurance for your prescription drug costs throughout the year, up to a combined medical and pharmacy Out Of Pocket maximum of \$5,750 for single and \$11,500 for member with dependent coverage per year.
- **Plan C.** Until you reach your deductible, you will pay 100% of the discounted cost for your prescription drugs when you present your Caremark ID card. Once you have reached your annual health plan Deductible, you pay a Coinsurance for your prescription drug costs throughout the year, up to a combined pharmacy and medical Out Of Pocket maximum of \$5,000 for single and \$10,000 for family. See pages 4 and 22 - 23 for Plan C pharmacy tiers and Coinsurance.

Regardless of which plan you elect, your Out Of Pocket costs will be lower if you use generic and/or preferred brand name drugs. The PDL is available at either: [www.kdheks.gov/hcf/sehp/Caremark.htm](http://www.kdheks.gov/hcf/sehp/Caremark.htm) or [www.caremark.com](http://www.caremark.com)

You can also call Caremark at 800-294-6324 for help finding a preferred drug. A number of popular name brand drugs are projected to be available in generic versions during 2017. This list is also on the website.

Before talking to your physician about prescriptions, it is suggested that you print out the Preferred Drug List (PDL) from the website and take it to any appointments so you can discuss your options. The Caremark plan is designed to encourage you and your health care provider to choose the most cost-effective and clinically-effective medications available. Home delivery is available through Caremark and reorders are processed in as little as five to seven days. To place an initial order or reorder by phone, call 1-800-294-6324 or e-mail [online@caremark.com](mailto:online@caremark.com)

Specialty and biotech drugs are designed for difficult conditions that don't respond to traditional therapy. A complete list of Specialty Drugs is available at [www.kdheks.gov/hcf/sehp/Caremark.htm](http://www.kdheks.gov/hcf/sehp/Caremark.htm) These drugs are available only through the Caremark Connect Specialty Pharmacy. Contact Caremark Connect at 1-800-237-2767. A Caremark representative will coordinate patient care with the provider and arrange for medication delivery.

For more information, go to [www.kdheks.gov/hcf/sehp/Caremark.htm](http://www.kdheks.gov/hcf/sehp/Caremark.htm)



## Dental Plan

Member only Dental coverage will now have a semi monthly premium of \$6.00. Employees can now opt out of enrolling in dental coverage or elect a different tier election than their medical enrollment.

Any Dependents enrolled in dental coverage must be enrolled in medical coverage. Dependent dental coverage may not be dropped during the plan year unless dependent medical coverage is also dropped due to a qualifying event.

You have access to two Delta Dental provider networks.

**Delta Dental PPO Network** - The PPO Network Providers have agreed to a reduced fee for providing dental services. As a result, you generally pay a lower percentage of the total bill than you would when using a Premier (or Non Network) Provider. The PPO network for our group includes all PPO providers in the national DeltaUSA PPO network. Participants have the option to use the PPO providers whenever desired.

**Delta Dental Premier Network** - Delta Premier Dentists agree to accept the plan allowance as payment in full. You will be responsible for paying only the specific Coinsurance and Deductibles for covered services in addition to any services not covered.

See page 20 for Basic and Enhanced Coverage information.

For more details on Delta Dental Benefits, go to [www.kdheks.gov/hcf/sehp/Delta.htm](http://www.kdheks.gov/hcf/sehp/Delta.htm)



You are offered two vision plans through *Surency Life and Health*, a Kansas-based company wholly owned by our dental carrier, Delta Dental of Kansas. See page 21 for details on the plans.

Surency partners with *EyeMed Vision Care* for your vision care provider network. Surency's *Insight* network of providers offers you the choice of independent providers or retail providers, such as *LensCrafters*, *Target*, *Sears and Walmart* to name a few. There are more than 700 providers at more than 200 locations for you to utilize. You may search for a provider near you at: [www.surency.com/stateofkansas](http://www.surency.com/stateofkansas).

Through Surency, you have access to their many value-added benefits which help you save money all year long. These include Glasses.com and ContactsDirect.com where you may access and use your benefits in their online superstores that offer a wide variety of the world's leading brands of frames and lenses.

Surency members may also receive a 40% discount for additional purchases of complete pairs of eyeglasses when using a participating EyeMed provider. Check with the Surency State of Kansas Insight Network to make sure that your provider is participating in the additional discounts provided. With the Sunperks discount plan, you'll receive a \$50 discount at any Sunglass Hut (no minimum purchase necessary). More information on these plans and other value added benefits can be found at: [www.surency.com/stateofkansas](http://www.surency.com/stateofkansas)

## Preferred Lab Benefit Available with Plans A and C

**For Plan A:** Present your State Employee Health Plan ID card identifying your membership. When you use a participating laboratory, either Quest Diagnostics or Stormont-Vail/Cotton-O'Neil, for outpatient non emergency testing that is covered and approved by your health benefit plan, you pay **no** Deductibles, Copays or Coinsurance.

**For Plan C:** Present your State Employee Health Plan ID card identifying your membership. When you use a participating laboratory, either Quest Diagnostics or Stormont-Vail/Cotton-O'Neil, for outpatient non emergency testing that is covered and approved by your health benefit plan. After you meet the Deductible, covered outpatient lab tests performed by the Preferred Lab providers are paid at 100% by the Plan. **Note:** You may pay these claims with your Health Savings Account dollars.

If your doctor doesn't use Quest Diagnostics or you are not a Cotton-O'Neil patient, bring the lab orders from your doctor to one of the locations provided by Quest Diagnostics or Stormont-Vail/Cotton-O'Neil to have the lab work done and receive either benefit.



**Quest Diagnostics** offers collection sites at various locations throughout the State of Kansas and nationwide. Also, you can arrange to have specimens picked up from your doctor's office. All it takes is a telephone call to the number on the back of your Quest ID card.



**Stormont-Vail/Cotton-O'Neil** offers 10 locations in northeast Kansas for all State Employee Health Plan members. You do not have to be a Cotton-O'Neil patient to access this benefit. Lab orders from your physician are required.

**PLEASE REMEMBER:** You must verbally request to use your Preferred Lab Benefit.

### The Preferred Lab Benefit Program does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency or STAT basis
- Testing done at any other laboratory
- Non-Laboratory work such as mammography, x-rays, imaging and dental work
- Time-sensitive, esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests
- Testing not approved and/or covered by the State of Kansas Plans A or C
- Lab work billed to your health plan by your doctor or another laboratory

**The Preferred Lab Benefit is completely voluntary.** If you and your health care provider choose to use a lab other than those provided by either Quest Diagnostics or Stormont-Vail HealthCare you still have laboratory coverage. However, you will be responsible for any Deductible, Copayments or Coinsurance applied by the health plan.

For details, go to [www.kdheks.gov/hcf/sehp/PreferredLab.htm](http://www.kdheks.gov/hcf/sehp/PreferredLab.htm)

## 2017 Monthly Rates for COBRA Participants

Employee Category	PLAN A		PLAN C		Delta Dental	Surency Vision	
	Aetna	BCBS	Aetna	BCBS		Basic	Enhanced
State COBRA Rates							
Member Only	\$596.23	\$588.50	\$465.55	\$452.35	\$45.07	\$4.04	\$7.95
Member + Spouse	\$1,166.68	\$1,113.96	\$786.93	\$755.90	\$75.79	\$7.91	\$15.68
Member + Children	\$1,028.83	\$995.91	\$715.65	\$692.68	\$72.45	\$7.14	\$14.14
Member + Family	\$1,406.97	\$1,375.69	\$925.79	\$880.59	\$89.14	\$11.03	\$21.92
Non State Employer Group COBRA Rates							
Member Only	\$702.57	\$694.40	\$569.46	\$556.15	\$55.80	\$4.04	\$7.95
Member + Spouse	\$1,508.99	\$1,455.45	\$1,137.84	\$1,104.12	\$103.34	\$7.91	\$15.68
Member + Children	\$1,370.76	\$1,337.09	\$1,060.86	\$1,036.09	\$100.01	\$7.14	\$14.14
Member + Family	\$1,820.83	\$1,732.61	\$1,293.97	\$1,243.70	\$116.67	\$11.03	\$21.92

## Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
<b>Basic Provisions</b>				
<b>Provider Choice</b>	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status			
<b>Annual Deductible</b>	<b>\$1,000 / \$2,000 / \$3,000</b>	<b>\$1,200 / \$2,400 / \$3,600</b>	\$2,750 Single / \$5,500 Family	\$2,750 Single / \$5,500 Family
	Employee Only - \$1,000 Employee & 1 - \$2,000 Employee & 2+ - \$3,000	Employee Only - \$1,200 Employee & 1 - \$2,400 Employee & 2+ - \$3,600		
<b>Annual Coinsurance</b> <i>(for all eligible expenses, unless otherwise noted)</i>	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
<b>Out Of Pocket-Max - (OOP) TOTAL</b>	\$5,750 Single / \$11,500 Family	\$5,750 Single / \$11,500 Family	\$5,000 Single / \$10,000 Family	\$5,000 Single / \$10,000 Family
<b>Covered Services</b>				
<b>Inpatient Services</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Physician Hospital Visits</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Physician Office Visits</b>				
Primary Care Provider	\$40 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Specialist	\$60 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Urgent Care Center	\$50 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Outpatient Surgery</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Emergency Room Visits</b>	\$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	\$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
<b>Other Outpatient Services</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Ambulance Services</b>	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
<b>Major Diagnostic Tests</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance

## Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
<b>X-Ray and Laboratory</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Rehabilitation Services:</b> <i>Services are limited to those medically necessary, and appropriate medical records must show continued improvement.</i>				
Inpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Outpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Office-Based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Durable Medical Equipment</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Allergy Testing</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Antigen Administration:</b> <i>desensitization/ treatment; allergy shots</i>	Covered in Full	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Autism Services</b>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Manipulation Therapies -</b> <i>Limited to 30 visits per year</i>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Licensed Dietitian Consultation:</b> <i>for medical management of documented disease</i>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
<b>Mental Health</b>				
<b>Mental Illness &amp; Drug or Alcohol Treatment:</b>			<b>Same Coverage as Medical</b>	
<b>Preventive Care:</b> <i>Limited to one visit or service per year unless otherwise noted. Review the Benefit Description for details on exact coverage.</i>				
<b>Well Baby Exams</b> <i>includes newborn screenings &amp; age appropriate office visits</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Well Child Exam</b> <i>includes office visit, age appropriate screenings and counseling</i>	Covered in Full	Not Covered	Covered in Full	Not Covered

## Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
<b>Well Woman Exam</b> <i>includes office visit, age appropriate screenings, contraception and counseling</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Well Man Exam</b> <i>includes office visit, age appropriate screenings, contraception and counseling</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Prenatal Screenings and Counseling</b> - see Benefit Description for list of covered services	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Age Appropriate Bone Density Screening</b>	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Immunizations</b>	Covered in Full	Covered in full to age 6, otherwise Deductible & 50% Coinsurance	Covered in Full	Covered in full to age 6, otherwise Deductible & 50% Coinsurance
<b>Mammography</b> (not limited to one)	Covered in Full	Deductible & 50% Coinsurance	Covered in Full	Deductible & 50% Coinsurance
<b>Colonoscopy</b> (not limited to one)	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Ultrasonography for Aortic Aneurysm</b> - limited to men ages 65 to 75 with history of tobacco use	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Routine Hearing Exam</b>	Covered in Full	Not Covered	Covered in Full	Not Covered
<b>Vision Exam</b>	1st Exam of year Covered in Full	Not Covered	1st Exam of year Covered in Full	Not Covered

The Comparison Chart is NOT the governing document. Members need to refer to the Benefit Descriptions posted on each vendor page on the SEHP website - [www.kdheks.gov/hcf/sehp/default.htm](http://www.kdheks.gov/hcf/sehp/default.htm) or contact the vendor directly if there are coverage questions. Contact information for all SEHP vendors is on the 1st page of this booklet.

Delta Dental Benefits			
	PPO Network Provider	Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	\$1,700 per member		
Lifetime Orthodontic Benefit	50% Coinsurance to a maximum of \$1,000 per member		
Implant Coverage <i>(Benefit subject to Annual Benefit Maximum above)</i>	50% Coinsurance		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	\$50 per person per Plan Year. Not to exceed an Annual Family Deductible of \$150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT Applies when you have not had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	60%	70%	70%
ENHANCED BENEFIT Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%
<i>*Services by Non Network Providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.</i>			
<i>Your Coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxes (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.</i>			

Surency Vision Benefits			
Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
<b>Eye Exams: Subject to \$50 Copayment</b>			
Eye Exam, M.D. <b>or</b> O.D	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$38
<b>Eyeglasses: Subject to \$25 Materials Copayment</b>			
Frame	Up to \$100 retail*	Up to \$150 retail*	Basic: Up to \$45 Enhanced: Up to \$78
Single Vision Lenses, pair	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$31
Bifocal Lenses, pair	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$51
Trifocal Lenses, pair	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$64
Lenticular Lenses, pair	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$80
Progressive Lenses, pair	Not Covered	Covered up to \$165*	Not Covered
High Index Lenses, pair	Not Covered	Up to \$116 retail *	Not Covered
Polycarbonate Lenses, pair	Up to \$40	Covered in Full	Not Covered
Scratch Coat	Up to \$15	Covered in Full	Not Covered
UV Coat	Up to \$15	Covered in Full	Not Covered
<b>Contact Lenses: Not subject to Materials Copayment</b>			
<b>NOTE:</b> Contact Lens allowance must be used in one (1) purchase each year.			
When Medically Necessary	Covered in Full	Covered in Full	Up to \$105
Elective/Cosmetic Retail	Up to \$150 retail*	Up to \$150 retail*	Up to \$105
<b>Contact Lens Exam (fitting fee) (\$35 Copayment)</b>			
Standard Contacts**	Covered in Full	Covered in Full	Not Covered
Specialty Contacts***	90% of charge, less \$55 allowance	90% of charge, less \$55 allowance	Not Covered
<p>* You are responsible for any charges above the allowance.</p> <p>** Standard contact lens fit and up to two follow-up visits covered once a comprehensive eye exam has been completed. Typical standard lenses include disposable, daily wear or extended wear lenses.</p> <p>*** Specialty contact lens fit and up to two follow-up visits covered once a comprehensive eye exam has been completed. Typical specialty lenses include toric, gas permeable and multi-focal lenses.</p> <p><b>NOTE:</b> Members may use their benefit for contact lenses OR spectacle lenses once per year, however the member's frame allowance can still be used if contact lenses are elected.</p>			



## Caremark Prescription Drug Benefits for Plan A

Preferred Drug List, Specialty Drug List and Discount Tier List available on the web at [www.caremark.com](http://www.caremark.com)

Tier	Type of Prescription Medication	You Pay	Your Out Of Pocket Maximum
1	<b>Generic Drugs</b>	20% Coinsurance	There is an Out Of Pocket maximum of \$5,750 for single and \$11,500 for family combined Medical and Pharmacy per year.
2	<b>Preferred Brand Name Drugs</b>	40% Coinsurance	
3	<b>Special Case Medications</b>	40% Coinsurance to a maximum of \$100 per standard unit of therapy / 30-day supply	
4	<b>Non Preferred Brand Name Drugs</b>	65% Coinsurance	
5	<b>Discount Tier Medications</b>	100% Coinsurance	N/A
6	<b>Anticancer Oral Medications</b>	20% Coinsurance to a maximum of \$100 per standard unit of therapy / 30-day supply	Applies to the Out Of Pocket maximum (See above)
Value Based	<b>Diabetes</b>	Generic - 10% to a max of \$20/30 day supply Preferred brand - 20% to a max of \$40/30-day supply	Applies to the Out Of Pocket maximum (See above)
Value Based	<b>Asthma</b>		

**Compound Medications now must be filled at Network Pharmacy only.**

## Caremark Prescription Drug Benefits for Plan C While Satisfying the Deductible

Tier	Type of Prescription Medication	
1	<b>Generic Drugs</b>	<p>Tiers 1-4 are subject to the Deductible.</p> <p>You/Your Family will be responsible for 100% of the cost of prescription drugs until the Deductible of \$2,750 Single / \$5,500 Family is satisfied. Once the Deductible is met, there is Coinsurance similar to Plan A until the Out Of Pocket maximum is satisfied.</p>
2	<b>Preferred Brand Name Drugs</b>	
3	<b>Non Preferred Brand Name Drugs</b>	
4	<b>Anticancer Oral Medications</b>	

Discount Tier Drugs are not covered and do not count toward the Health Plan Deductible.

**Compound Medications now must be filled at Network Pharmacy only.**

## Caremark Prescription Drug Benefits for Plan C After Deductible is Satisfied

Tier	Type of Prescription Medication	You Pay	Your Out Of Pocket Maximum
1	<b>Generic Drugs</b>	20% Coinsurance	There is an Out Of Pocket maximum of \$5,750 for single and \$11,500 for family combined Medical and Pharmacy per year.
2	<b>Preferred Brand Name Drugs</b>	40% Coinsurance	
3	<b>Special Case Medications</b>	40% Coinsurance	
4	<b>Non Preferred Brand Name Drugs</b>	65% Coinsurance	
5	<b>Discount Tier Medications</b>	100% Coinsurance	N/A
6	<b>Anticancer Oral Medications</b>	20% Coinsurance	There is an Out Of Pocket maximum of \$5,750 for single and \$11,500 for family combined Medical and Pharmacy per year.
<b>Compound Medications now must be filled at Network Pharmacy only.</b>			